Commission to Study Mental & Behavioral Health

WRITTEN TESTIMONY – September 14 2021

Testimony to Maryland Commission to Study Mental Illness and Behavioral Health, Howard County Sept. 14, 2021 by Janet Edelman

My name is Janet Edelman, I am the Chairperson of the Howard County Local Behavioral Health Advisory Board, a longtime member of NAMI and a family advocate for people living with a mental illness. I am speaking today as an individual.

First, I want to mention some of the things that are going well in Howard County. We are working on implementing a new regional crisis system, have just implemented LEAD for jail diversion, the school system has just expanded social workers to 20 additional schools. A new harm-reduction program was recently implemented and we have developed new educational programs. There is much work left to do.

Some large problems remain which are under the control of the state of Maryland. Optum's failure to pay Medicaid providers promptly have made it very difficult for providers. I cannot understand how after all of these years of managed care, the vetting process allowed Optum to be selected if they could not perform and that the BHA did not seem to have the tools to rectify the situation. I hope that someone makes sure that this is remedied the next time Maryland bids out for an ASO.

Concerning the Involuntary Commitment Stakeholders' Workgroup Report, I want to thank the Commission for studying this issue. I advocated, with others, for the change to the Maryland law in 2003 on the danger standard for emergency petitions. That change, along with the statewide training at the time, was not sufficient to significantly improve the danger standard in Maryland.

While the BHA proposal is an improvement, several weaknesses remain. Most concerning is that the proposal does not include psychiatric deterioration as a danger to self. I reviewed comments submitted by Brian Stettin of the Treatment Advocacy Center. Brian is an expert on this issue and his comments make a lot of sense to me.

The BHA proposal recognizes the need for improvement and clarification of the danger standard, and proposes extensive training on the new standard. I think that the inclusion of wording in the danger standard for someone who is unable to meet their basic needs is an important clarification.

The proposed changes do not go far enough. If you witness someone who is psychotic and has hallucinations and/or delusions that could affect their own well-being or those of someone else, it is imperative to step in to prevent harm. Many of the people in the commitment process do not have awareness of their illness as a direct result of their illness and cannot see their symptoms as a sign of disease. It does not take a psychiatrist to realize that someone, who for example, thinks his food is poisoned by the government, or who hears voices telling him to harm himself or others is a danger. As mentioned on page 10 of the report, there are several medical articles that describe deterioration of the brain as a result of untreated psychosis. This should certainly qualify as a danger to self.

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My brother has lived with schizophrenia and heard voices for over 50 years. He is an example of how people who are very ill, but medicated and with support, can live in the community successfully. For those whose illness does not allow them to accept help, Maryland allows them to deteriorate until they are so very ill that they may become homeless, in jail, cycle in and out of hospitals or be close to death. I believe that this is very wrong.

Thank you for giving me a chance to comment.

Comments on the Involuntary Commitment Stakeholders Workgroup Report of 8-11-21

My name is Patricia Sollock, and the purpose of this communication is to comment on the Involuntary Commitment Stakeholders Workgroup Report of 8-11-2021 that I understand will be reviewed by the Commission to Study Mental and Behavioral Health in Maryland. I have lived and worked in Maryland for 41 years and practiced as a licensed mental health provider and MH Director of two detention facilities, certified by the National Commission on Correctional Health Care, with an average daily population of approximately 700-750 inmates. Additionally, I have been a consultant and trainer nationwide for various Corrections facilities, as well as provided consultation and training for the National institute of Corrections, Federal Parole and Probation, and Federal Judicial Center. I have participated in Mental Health Commissions and presented on mental health topics at national conferences. I have numerous times testified on the irreversible negative impact that incarceration has on mentally ill persons, their families, and the community, and I have tirelessly advocated for humane treatment in professional settings, not jails. Throughout my years I have witnessed the pervasive criminalization of mental illness and use of jails as de-facto hospitals for this population. As an out-of-state consultant, I have learned about other mental health systems and became aware of Maryland's low ranking in facilitating commitment for individuals in the process of psychotic decompensation. Despite my experience and insights about the challenges that caretakers and providers face to prevent the incarceration of patients with mental illness, I submit these comments on my behalf and not on behalf of any institution or organization that I am or have been affiliated with.

Outpatient and correctional mental health providers, as well as community first responders, or caretakers, all relay frustration about their hands being tied when trying to access treatment and prevent negative outcome for persons psychiatrically decompensating in the community. The current "danger standard" is a barrier to needed hospital treatment and once incarcerated and sentenced, patients are no longer eligible for Court ordered evaluations. Those who refuse treatment continue to deteriorate and create major management problems for Administrators Correctional Officers and providers and because jails are not hospitals and thus restrictive housing is oftentimes the only way to ensure their safety and that of others. Even if two providers file certifications for hospitalization, this is the population that MDH has categorized as last priority for admission regardless of degree of impairment. This is because there are fines attached to delayed Court ordered evaluations while there are no penalties for not honoring physicians' certifications. This creates a terrible situation where hospital admissions are prompted by avoidance of penalty fees, rather than by patient need. The result is that some patients are likely to be released much more ill, less likely to respond to medication, more dangerous than when they entered jail, and even more likely to commit another crime that could also be more serious than previous ones. Outpatient programs may reject patients due their chronic involvement with the criminal justice system and/or history of non-adherence to treatment. This is the perfect storm for creating a criminal justice revolving door for mentally ill persons while their options for treatment and self-sufficiency are further reduced.
Allowing a psychotic person to arrive at such point of decompensation that his behavior results in incarceration, is callously disregarding the downward course of untreated psychotic decompensation, especially when the symptoms and performance indicate a deterioration of functioning known or believed to be leading to critical levels by any reasonable person. Sadly, the feared negative incarceration outcome, may result from misdemeanor offenses, although in some cases from very regrettable and tragic crimes such as murder of caretakers or innocent persons in the community that forever affect the patient, their families, and the community at large. Not surprisingly, oftentimes the public is astonished to learn after a tragic event affecting

more than just the patient, that the patient's caretakers had unsuccessfully exhausted all means to seek in-patient treatment but that the patient did not allegedly meet the current danger standard. The current 'danger' standard focuses on obvious (overt) danger to self or others yet disregards the documented dangers of 'covert' brain damage that progressively deteriorates due to chronic psychotic episodes, especially if untreated.

For years I have witnessed how we penalize patients for decompensating and for committing crimes while their judgment is impaired by delusions that torment them, but we do not admit responsibility for placing obstacles to treatment when they are in the process of decompensating at which time treatment is essential.

Recommendation:

For all the reasons presented and to try to halt the pervasive criminalization of persons with mental illness, ***I recommend the following:***

1. ***The inclusion of "psychiatric deterioration" in the current danger standard.***
   Note: the current danger standard only focuses on physical/medical deterioration and dismisses documented progressive brain deterioration in untreated psychosis reducing the life expectancy of persons with mental illness by 10-20 years.

2. ***The standard must clearly be defined and include***
   a. ***individual's personal and psychiatric history, if available***
   b. ***individual's level of performance deemed by any reasonable person to be heading to a deteriorating and dangerous course***
   c. ***specific clarification that danger is reasonably expected and need not be imminent.***
   d. ***danger to self as evidenced by deterioration of brain function or by physical deterioration due to psychosis.***

I believe it is time for conscientious citizens to facilitate early access to treatment instead of facilitating incarceration which is truly the ultimate infringement on a person's freedom and perpetuating the criminalization of mental illness. Jails offer patients criminal records that have lasting, critical negative repercussions in their lives.

I will gladly make myself available for any questions or clarifications related to this matter.

Sincerely Yours,

Patricia Sollock, MA, LCPC
Pss28@hotmail.com

Written testimony to: The Mental and Behavioral Health Commission, for the meeting on September 14, 2021

From: Christine L. Miller, Ph.D., 6508 Beverly Rd, Idlewylde, MD 21239, CMiller@millerbio.com, 443-520-0485

Topic: **Urgent need for educating the general public on marijuana. Maryland is ill-prepared for the anticipated 2022 ballot on marijuana legalization, with its serious potential for negative public health consequences.**

Dear Committee Members:

In all likelihood, the legislature will place marijuana legalization on the ballot by referendum next year and the multifaceted public health harms of marijuana use is something the general public should be educated on before casting their vote. The technical nature of this subject makes it very different than voting on whether gambling should be legalized, for example. Very few citizens in our state are aware of how the potency changes in marijuana products have led to substantial mental health harms, particularly in young users. **If they become educated on the issue, and still vote for marijuana legalization, then at least their choice will be based on knowledge rather than ignorance.**

The large scale, negative outcomes in the legalized state of Colorado experience became all too clear in oral testimony during a hearing this year to plug loopholes in their current regulations through enacting HB1317 (the bill begins at about the **3hr 4 min time point** in the podcast):

https://sg001-harmony.sliq.net/00327/Harmony/en/PowerBrowser/PowerBrowserV2/20210517/31/11695

Parent after parent stood up and testified about their son or daughter being a successful student or a star athlete until a friend introduced them to using marijuana concentrates, first becoming anxious, then depressed, then psychotic and in many cases, suicidal. All these outcomes are supported by abundant scientific literature as reviewed in two book chapters I have authored (see below). Only one woman spoke of the recovery of her teen from this downward spiral, and she now counsels other families, stating that she has worked with at least 1,000. Teachers and high school principals spoke of the impacts on their students. The horror of what the legislators heard eventually led to the bill being passed unanimously, though industry pressure forced amendments to strip the potency caps that had originally been proposed.

Although the loophole that was successfully tightened involved access to medical marijuana, it was the legalization of recreational marijuana in 2013 that normalized the drug in the minds of teens. The data show that teens in states with legalized recreational marijuana have rates of cannabis use disorder that are 25% higher than non-legalized states (Cerda et al., 2020 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6865220/), and the most devastating impact comes from their greater access to much more potent products, often in the form of vapes and

edibles (Borodovsky et al., 2017; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5534375/pdf/nihms880035.pdf).

Here is a riveting 5 minute testimony to the full House in Colorado, given by Rep. Judy Amabile, whose own son has little chance of recovery:

https://www.youtube.com/watch?v=PSQcCtOU2fs

The sad truth is that the stigma attached to mental health disorders, no matter what the cause, prevents many families from speaking out until a critical mass is reached, at which time they realize they are not alone.

Colorado has finally reached that critical mass. You have the opportunity to help prevent the same outcome for Maryland.

The CDC has been sponsoring public service announcements about the hazards of smoking during the Olympics, and their help in educating the public in a similar vein about marijuana's harms would be invaluable, rather than burying the information in a difficult to find corner of their website: https://www.cdc.gov/marijuana/nas/mental-health.html. I noticed a billboard near Eldersberg recently on the general topic of "choices" for teens (implicitly pointing away from drugs) sponsored by the Maryland Department of Health (photo attached). Much more should be done now by our state and federal agencies, with a clear message specific to marijuana.

Christine L. Miller, Ph.D.
Author of: The Impact of Marijuana on Mental Health, in: Contemporary Health Issues on Marijuana (K.Winters and K. Sabet, eds.) Oxford University Press, 2018; and Marijuana and Suicide: Case-control Studies, Population Data, and Potential Neurochemical Mechanisms, in: Cannabis in Medicine. An Evidence Based Approach (K. Finn, ed.) Springer Press, 2020

September 2, 2021

Attention: Maryland Behavioral Health Administration (BHA)

Re: Comments on the Involuntary Commitment Stakeholders Workgroup Report of August 11, 2021

Dear Concerns Parties,

My name is Karen Logan and I am the mother of a son that suffers from a form of schizophrenia. He has been incarcerated in the Maryland Correctional System for 19 years in a special unit for individuals with mental illness. His symptoms' became apparent when he was in his early 20s. His name is James Logan and at the time he was married with two young sons, one 2 and the other about 6 months old.

We tried to get him treatment in the summer of August 2002 once we realized something was very wrong, eventually pleading with a Judge to at least have him admitted into a hospital for treatment. The results, unfortunately lead to devastating consequences causing the death of two sheriff officers that tried to take him to a hospital. Now close to 20 years, much has happen since that dreadful day. His two sons are now grown, one a college student and the other a recent high school graduate working. He is on a medication that keeps him staple that allows him to function, enabling him to learn music, work and acquire other skill sets to equip him to return to society upon release.

I am asking that BHA propose the inclusion of a psychiatric deterioration standard that would include psychosis itself, as a danger to the individual because people that have severe mental illness do not recognize they are sick. If untreated they might have brain damage, become homeless, incarcerated or even die prematurely.

I am asking and really pleading that the definition put forth, clearly specify that the danger need not be current or imminent, but is **reasonably expected in the foreseeable future**. My son will be released to society in the near future. Our family and the officers' family have experienced hardships that are hard to put into words. Why allow anyone with a mental condition to deteriorate to the point where their behavior creates a substantial risk for bodily harm, serious illness or death? Why would anyone allow that when it can be prevented?

Again, I am asking that you consider the fact that the lack of treatment could lead to future harm. I have seen this first hand. Thank you for your consideration to this important matter.

Sincerely,

Karen Logan

Comments on the Involuntary Commitment Stakeholders' Workgroup Report of Aug. 11, 2021

By: Marilyn Martin, mother of adult son diagnosed with schizophrenia

I am writing in opposition to your proposed danger standard for involuntary psychiatric evaluation and hospital commitment. It appears to me that our state would slide backward in that the word, imminent, which was removed from the standard a couple of decades ago, would now be replaced by the word, "current." Going backward with this "imminent or current" language, will most assuredly lead to more people with these neurological illnesses becoming homeless, murdered by cop, or imprisoned. I believe that laws written to promote violence have no place in a civilized society. Involuntary commitment was the only route for my son's safety on several occasions. He was diagnosed with schizophrenia when he was 24 years old. Our family has had to face these crises for more than a decade. Just to cite several examples:

- In 2009 my son refused to take medication, believing that he was not ill. He was still able to care for himself physically, but he experienced psychiatric deterioration with paranoid delusions. When his delusions included a threat to kill someone who was driving by his home, I petitioned the court for an emergency evaluation. The judge denied it for lack of "immediacy," although the law no longer stated that the danger be imminent. It is my understanding that training had been tried prior to this but did not include judges. Health regulations cannot mandate training for judges. This is one reason it is imperative that the danger definition be put in statute, not regulations. Judges give deference to what the statute says, which is why it must be made clear IN STATUTE that the danger need not be imminent or "current" but can be "reasonably expected in the foreseeable future."
- In April 2013, my son was clearly showing signs of psychiatric deterioration with paranoid delusions. His psychiatrist failed to petition for emergency evaluation. For two months, he

deteriorated further to the point where he threatened a neighbor. Even then, the police failed to petition.

- In January 2016, my son was visiting me and my husband in Chesapeake Beach. Again, it was clear that my son was experiencing psychiatric deterioration with his early warning signs of psychosis. I expressed my concerns to his clinic director. Unfortunately, my son deteriorated to a full blown psychosis; however, his treatment team did not petition for emergency evaluation. The next time my son visited, without warning, he picked up my 70-year-old husband by his neck. He pounded his fist into my husband's head, believing that my spouse was responsible for 9-11. When I tried to intervene, my son pushed me into a wall. This episode finally ended with my dialing 911. We were so fortunate that an officer trained in de-escalation arrived at our house. The officer took my son to our local hospital, where he spent the next couple of days waiting for a bed at a hospital that could take someone who was "dangerous," with a history of violence. Waiting for an individual to become violent before they qualify for emergency evaluation not only contributes to the damage being done to his brain for lack of timely treatment but contributes to overcrowded ERs since it takes more time to find a hospital placement for those with a history of violence.

Research scientists have known since the 90s that schizophrenia is a neuro-developmental disorder. Now, scientists have strong evidence that psychosis is toxic to the brain. * Therefore, allowing someone with this disorder to become psychotic to the point of posing "a substantial risk for bodily harm, serious illness or death," as this working group has proposed, is exacerbating his disability and the danger to those around him or her. Why were "mental harm" and serious "psychiatric" illness rejected by this group? It appears that our Behavioral Health Administration does not care about what happens to our loved ones or their families with psychosis from mental illness. We would never allow our senior citizens with Alzheimer's to deteriorate to the point of being dangerous or lost before helping. Our youngsters

with these neurological disorders are just as loved and valued to their families as our elderly are. Please do not define danger so that it becomes even more difficult to obtain treatment when loss of insight occurs (anosognosia). Please, let us not backslide for getting our loved ones back on track with proper medication!

*Gerald Martone. "Is psychosis toxic to the brain?" *Current Psychiatry*, April 2020, p, 12-13, https://cdn.mdedge.com/files/s3fs-public/CP01904012.PDF